As a Blue Cross and Blue Shield of Kansas (BCBSKS) contracting provider, you receive the services of a professional relations staff dedicated to providing you with easy-to-access information regarding policy memos and information.

Below are highlights of BCBSKS Policy Memos. For the complete policy, please refer to the specific link.

In addition, this online manual provides detailed information about the claims/reimbursement process. The internal links allow you to point and click your way through the manual.

NOTE: The revision date appears in the footer of each document. Links within the document are updated as changes occur throughout the year.
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Section 1: Competitive Allowance Program (CAP) Letter

- Mailed in July
- Approved by BCBSKS Board of Directors
- Includes updates for the upcoming year
- Your charge comparison report is available

To view the current letter, click on

[CAP Contract Letter]
Section 2: Policy Memos

BCBSKS Policy Memos apply to all contracting providers. Please review applicable policies at the links provided below.

Policy Memo No. 1 – Policies and Procedures

Policy Memo No. 1

- Medical Review Processes
- Corrected Claim
- Retrospective Claim Reviews
- Denied Claims Appeals Procedure
- Post-Payment Audits
- Utilization Review & Medical Necessity
- Content of Service
- Experimental or Investigational Procedures
- Non-Covered Services
- Patient-Demanded Services
- Waiver Form
- Medical Records
- Uniform Provider Charging Practices
- Purchased Services
- Professional Services Coordinated with a Non-Contracting Provider
- Claims Filing
- Refund Policy
- Right of Offset
- Services Provided by Non-Physicians and Resident Physicians
- Locum Tenens Provider
- Contracting Status Determination
- New Techniques and Technology
- Reimbursement and Policy Changes
- Amendments to Policies and Procedures; Right to Terminate Contract
- Establishing and Amending Medical Policy
- Tiered Reimbursement and Provider Number Requirements
- Reimbursement for New Procedure Codes
• Reimbursement for Pharmaceuticals
• Reimbursement for Sleep Study Testing
• Reimbursement for Lesser Services
• Reimbursement for Quality
• Reimbursement for Site of Service
• Adverse Events
• Application of Contract
• Acknowledgment of Independent Status of Plan
• Acknowledgment of Balanced Budget Act of 1997
• Contract Scope of Services
• Charge Comparison Reports
• Pathology or Laboratory Services
• Special Provision Pertaining to Pended Claims
• Limited Provider Networks
• CAP Provider Directories
• Acknowledgment of the Health Insurance Portability and
  Accountability Act (HIPAA) Privacy Regulations
• Acknowledgment of K.S.A. 44-1030
• Medicare Advantage Claims
• Limited Patient Waiver Form
• Collection of Payment
• Contract Amendment
Policy Memo No. 2 – Office/Outpatient Visits

Policy Memo No. 2

- Definitions – Patient Status (New vs. Established)
- Content of Service
- Service Qualifying for a Separate Professional Fee in Addition to an Office/Outpatient Visit
- Qualifications for Individual Consideration of Unusual Office/Outpatient Visit Charges
- Outpatient Consultations
- Additional Policy Clarification
Policy Memo No. 3 – Outpatient Treatment of Accidental Injuries and Medical Emergencies

Policy Memo No. 3

- Definitions (Medical Emergency / Accidental Injury)
- Content of Service
- Critical Care Services
- How to Bill for Treatment of Accidental Injuries and Medical Emergencies In a Hospital Emergency Department
- Additional Policy Clarification
Policy Memo No. 4 – Quality of Care

Policy Memo No. 4

- Quality Improvement Program
- Member Satisfaction Survey
- Disease Management
- Health Insurance Portability and Accountability Act (HIPAA)
- State Health Information Exchange (HIE)
- Quality Reporting and Transparency
- Credentialing
Policy Memo No. 5 – In-Hospital Medical (Non-Surgical) Care

Policy Memo No. 5

- Daily Hospital Medical Services (New or Established Patient)
- In-Hospital Consultations
Policy Memo No. 6 – Concurrent Professional Care

Policy Memo No. 6

- Instances When Concurrent Care Policy Applies
- Instances Where Concurrent Care Policy Does Not Apply
- Reporting of Concurrent Care on Claims
Policy Memo No. 7 – Radiology and Pathology

Policy Memo No. 7

- Diagnostic Radiology Policy
- Therapeutic Radiology Policy
- Pathology
Policy Memo No. 8 – Obstetrical Services

Policy Memo No. 8

- OB Services – Non Surgical Content of Service
- OB Services – Surgical Content of Service
- Services Qualifying For Additional Fees
- Additional Policy Clarification
- Additional Obstetrical Procedures
Policy Memo No. 9 – Surgery

Policy Memo No. 9

- Global Fee Concept
- Physicians Who Furnish Entire Global Package
- Physicians in Group Practice
- Providers Furnishing Less than the Full Global Package
- Date(s) of Service
- Reimbursement
- Unusual Circumstances
- Discharge Procedures By Someone Other Than The Surgeon
- Additional Policy Clarification
- Adverse Events
Policy Memo No. 10 – Assistant Surgery

Policy Memo No. 10

- Medical Necessity Guidelines
- Reimbursement
- Preoperative and Postoperative Care
- Non-Physician Assistants
Policy Memo No. 11 – Multiple Surgical Procedures

Policy Memo No. 11

- Multiple Surgical Procedures When Performed By One Provider
- Endoscopies, Arthroscopies, and other Scope Procedures
- Other Policy Provisions
Policy Memo No. 12 – Anesthesia

Policy Memo No. 12

- Description
- Time of Administration
- Content of Services Within Usual Anesthesia Fee
- Surgical Procedures And Nerve Blocks Performed By The Same Anesthesia Provider
- Method Of Determining The Maximum Allowable Payment (MAP)
- Related Policies
Section 3: How to Complete a CMS 1500 Claim Form

The CMS 1500 Claim Form is a universal claim form used by the government and commercial insurance companies. The CMS 1500 is the designated format to submit paper claims to BCBSKS. BCBSKS encourages the submission of claims electronically using the ANSI ASC X12N 837 Health Care Claims transactions.

Go to bcbsks.com for a tutorial of the CMS 1500 Claim Form.
**Section 4: Procedure Code Listings**


It is important to maintain current resources when coding.

Quarterly changes are made to the AMA-CPT and HCPCS code books. The changes are effective the first date of each quarter (i.e., Jan. 1, April 1, July 1, and Oct. 1). There is no grace period.

The ICD-10 code book has biannual changes. These changes are effective April 1 and Oct. 1 of each year. There is no grace period.

BCBSKS has developed procedure code listings by categories to assist you when filing and posting claims.

Click on the following listings:

- **Assistant Surgery Not Medically Necessary (NMN) Listing**
  Will be denied as NOT medically necessary for codes on the list. Assistant Surgery will be allowed for those codes marked with an (*) when performed in a physician’s office.

- **Major/Minor/Zero Surgery Codes – Effective Jan. 1, 2014,**
  BCBSKS is following Medicare's post-op period directive for minor/major and zero day surgery codes.

  - **Medicare Fee Schedule**

  - **Preventive Services Quick Reference Guide**
    This brochure identifies the health care reform preventive health benefits with recommended CPT® and diagnosis codes.

  - **Archived Lists**
    This links to an archived list by date of each of the above listings.
Section 5: Blue Card

The BlueCard program is a system that serves Blue Cross Blue Shield (BCBS) members worldwide. This means that claims for members of other Blue Plans should be submitted directly to BCBSKS.

Home Plan:

The BCBS Plan where the patient's policy was issued.

Host Plan:

The BCBS Plan where the services are rendered.

As a provider in the BlueCard network, the following applies:

- BCBSKS pricing and medical policies are followed for services to BlueCard members.
- You are considered a BlueCard PPO (Preferred Provider Organization) provider.
- For out-of-state BCBS members, the identification card will have a suitcase logo located in the right-hand corner to signify the BlueCard.
- For services that require pre-certification, check the number on the back of the member's identification card.
- To verify the status of a BlueCard claim, call: 1-800-432-3990, ext 4058 or 785-291-4058

To learn more about BlueCard, click on the link below.

Understanding Blue Card Module
Section 6: Other Party Liability (OPL)

Other Party Liability refers to the anti-duplication provision of the patient's contract that limits benefits paid by multiple insurers to 100 percent of the expenses covered and to designate the order in which the liability falls. Other Party Liability is an important cost containment measure that saves health care dollars of Blue Cross and Blue Shield (BCBSKS) members.

Understanding the Process

- **What is OPL?**

  The definition: Other Party Liability (OPL) coordinates benefits with the group health insurance policies, workers' compensations, and auto insurance as a cost containment measure to avoid duplicate payments on the same claim.

  This cost-containment feature reduces the amount of money Blue Cross and Blue Shield of Kansas (BCBSKS) pays and helps lower premium costs.

- **What about Group and Non-Group?**

  All BCBSKS group* contracts include a non-duplication of benefits provision. This provision applies whenever a member is eligible for benefits from more than one health care coverage plan.

  NOTE: This does not apply to individual non-group health care policies or Medicaid. Non-group policy numbers begin with "M", "08" or "MPN 714553005".

  *Group:
  The business organization or legal entity which entered into the contract with BCBSKS, for the provision of medical and hospital services.
**Non-Group:**
An individual who has entered into a contract with BCBSKS, for the provision of medical and hospital services.

- **How to Identify if OPL Applies**

Each time a member presents for services the following current insurance information must be obtained:

- Duplicate Coverage from another insurance policy
- Workers’ Compensation
- Personal Injury Protection (PIP) (auto no-fault coverage)

**NOTE:** Obtaining this information prior to filing the claim helps ensure prompt and accurate claims payment.

- **Pay and/or Pursue**

OPL will pay and pursue only duplicate coverage investigations. We pursue complete information before payment for FEP, workman's compensation, and auto/no-fault investigations.

- **Order of Benefit Determination**

Insurance information obtained from the patient determines which insurance policy is primary.

- **MEMBER RULE:** If the patient is the member named on the identification card, that policy is primary.

- **BIRTHDAY RULE:** If the patient is a dependent child, the insurance policy carried by the parent whose birthday occurs first in the calendar year is the primary policy. Age is not a factor when applying the Birthday Rule.
DIVORCE AND LEGAL SEPARATION RULE:

1. If the court states one parent is financially responsible for a dependent child's medical expenses, that parent's policy is the primary.

2. If the court does not state which parent is financially responsible for a dependent child's medical expenses, the parent with legal custody is the primary policy holder.

3. If the court states the parents have joint custody the Birthday Rule will apply, without a judicial decree stating otherwise.

4. If either or both parents remarry, the benefits of the stepparent married to the primary natural parent will be the primary before those of the other natural parent.

What is Workers' Compensation?

Workers' Compensation provides coverage for employees with work-related illnesses or injuries. If services are provided to a patient with an on-the-job illness or injury, specific information regarding the accident or injury is always needed on the claim.

When completing the claim form, note that it was an on-the-job illness or injury by marking the appropriate box and providing the accident date.

NOTE: It is important to file claims to each insurance company at the same time to avoid a Blue Cross and Blue Shield of Kansas (BCBSKS) 15-month timely filing denial.
Workers' Compensation Rules:

Services provided as the result of work-related illness or injuries would NOT be covered by BCBSKS when worker's compensation applies to your patient.

If the patient agrees to a settlement waiving their rights to future medical payment, BCBSKS will NOT pay for services that would have been payable by workers' compensation.

When workers' compensation requires specific health care providers be utilized, BCBSKS will NOT pay balances of charges from non-specified providers.

• How to Handle Personal Injury Protection

Personal Injury Protection (PIP) benefits apply to any accidental, bodily injury out of ownership, operation, maintenance or use of a motor vehicle. Motorcycles have the option to purchase PIP benefits.

If services are provided to a patient with a motor vehicle related injury, specific information regarding the accident is always needed on the claim.

When completing the claim form, note that it was a motor vehicle related injury by marking the appropriate box and providing the accident date.

NOTE: A letter of denial of benefits from the automobile insurance or an itemization of PIP payments is required for Blue Cross and Blue Shield of Kansas (BCBSKS) to process motor vehicle accident related claims.

NOTE: Auto, of course, is Primary, but it is important to file claims to each insurance company at the same time to avoid a BCBSKS 15-month timely filing denial.

• How to Indicate OPL on a Claim Form

The primary carrier's EOB is not necessary when filing the claims electronically. That information may be submitted through the 835
electronic claim format. If you file with paper, the other carrier's proof of payment is necessary to submit with the claim.

- **How Do I Reconcile My Accounts?**
  - **When both policies are Blue Plans:**
    - **Individual and Group Policies:** Compare the allowances of the primary and secondary carriers, and the larger of the two write-offs must be taken.
    - **Two Group Policies:** Providers must accept the primary carrier's write-off (assuming the provider has a contracting arrangement).
  - **When primary coverage is another commercial carrier and the secondary is a Blue Plan:**
    - If the primary coverage is another commercial carrier and the secondary is BCBSKS, and the secondary balance is greater than our allowable, you are required to take our write-off.

- **How Far Back Can Refunds Be Requested?**
  
  All OPL related refund requests are subject to a three year statute of limitations. Refunds will be covered through the auto-deduct process on the Remittance Advice.

- **What is an OPL Questionnaire?**
  
  An OPL Questionnaire is available for your use. BCBSKS encourages you to have patients complete the questionnaire at their first visit to your office to expedite claims processing. Simply fax directly to our office at 785-291-8981. Information will be loaded onto the member's account so when the first claims come to us, they can be processed without delay. A copy of the form is a part of this handout, or is available any time online through our website.

  **OPL Questionnaire**

  If additional questions arise regarding OPL, contact the BCBSKS OPL Customer Service direct at: 1-800-430-1274 or in Topeka, 291-4013.
Section 7: Remittance Advice (RA)

The Remittance Advise is a computer generated report that explains the processing of a claim. There is usually more than one claim on an RA and it can list many patients. Providers usually post these entries to their accounts receivable.

The electronic standards for remittance advice have been applied to the paper remit for consistency and to allow more claim adjudication detail fields on the paper remit.

In 2003, BCBSKS implemented Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets implementation. These are mandated remark and adjustment reason codes. Lists of these codes with a description are available through the Washington Publishing Company.

Paper vs. Electronic?

How can you tell whether the claim was processed as a paper claim or electronic claim? When claims are received by Blue Cross and Blue Shield of Kansas, a control number is assigned to the document. The first 2 digits of the 12-digit number help to identify whether the claim was received in a paper or electronic format. The 3rd and 4th digit identify the year in which the claim was received. The 5th through 7th digit identifies the Julian date or number of days in the year that it was received. The remaining digits represent the sequence in which the claim was received/controlled on the date the control number was assigned. Occasionally, there will be a suffix added to the claim which indicates that an adjustment was completed.

The claim number is reported to you in the left-hand column of the Remittance Advice below the individual patient name.

Claims beginning with 20 indicate they were received in paper form. Claims beginning with 38 indicate they were received in paper form with attachments such as medical records. Claims beginning with 25 and 57 indicate they were received in an electronic (paperless) format.
Let's break down a control number for example:

201000500001

20 - The claim came in as a paper claim.  
10 - It was received in 2010. 
005 - It was received on the 5th of January. 
00001 - It was the first claim in the sequence.

Click on BCBSKS newsletter link below for RA details on 3/26/03, S-05-03.

BCBSKS Newsletter S-05-03

A list of Remittance Advice remark codes is available at: Washington Publishing Company.

Washington Publishing Company | EDI | HIPAA | XML  
(Select “Code Lists”)
Section 8: Communicating with BCBSKS

Blue Shield Professional Relations

Questions We Answer For Providers

1. Instruct providers on the correct method of completing a CMS 1500 claim form.
2. Answer questions about CPT, HCPCS and ICD-10 coding.
3. Clarify newsletter information.
4. Answer provider contract, policy and procedure questions.
5. We accept written notice of any changes that affect the provider file.
6. Distribute Charge Comparisons upon provider request.
7. Send out contracting packets to Kansas providers who have recently started practicing, had a status change, or have recently had a tax identification number change.
8. Research provider issues and follow through with provider education when necessary.
9. Initiate provider credentialing activity.

Click on the link below for detailed contact information for BCBSKS.

Important Contact Information

<table>
<thead>
<tr>
<th>Professional Relations Staff</th>
<th>Location</th>
<th>Phone Number</th>
<th>Ext.</th>
<th>Phone Ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doug Scott, Director</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8831</td>
<td></td>
<td>(785) 291-8831</td>
</tr>
<tr>
<td>Robyne Goates, CPC</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8206</td>
<td></td>
<td>(785) 291-8206</td>
</tr>
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<tr>
<td>Robyne Goates, CPC</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8206</td>
<td></td>
<td>(785) 291-8206</td>
</tr>
<tr>
<td>External Manager (PR Reps)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8709</td>
<td></td>
<td>(785) 291-8709</td>
</tr>
<tr>
<td>Cathy Holmes, RHIT, CPHIT</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8709</td>
<td></td>
<td>(785) 291-8709</td>
</tr>
<tr>
<td>Internal Manager (Provider Network Services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christie Blenden, CPC</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8651</td>
<td></td>
<td>(785) 291-8651</td>
</tr>
<tr>
<td>Diana Evans, CPC</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8716</td>
<td></td>
<td>(785) 291-8716</td>
</tr>
<tr>
<td>Darin Fieger, CPC</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 8207</td>
<td></td>
<td>(785) 291-8207</td>
</tr>
<tr>
<td>Vikki Lindemuth*</td>
<td>Topeka</td>
<td>1-800-432-0216 ext. 7724</td>
<td></td>
<td>(785) 291-7724</td>
</tr>
<tr>
<td>Gwen Nelson, CPC</td>
<td>Dodge City</td>
<td>1-800-432-0216 ext. 4237</td>
<td></td>
<td>(620) 225-0884</td>
</tr>
<tr>
<td>Debra Meisenheimer, CPC</td>
<td>Hutchinson</td>
<td>1-800-432-0216 ext. 7137</td>
<td></td>
<td>(620) 663-1313</td>
</tr>
<tr>
<td>Kyle Abbott, CPC</td>
<td>Wichita</td>
<td>1-800-432-0216 ext. 1674</td>
<td></td>
<td>(316) 269-1674</td>
</tr>
<tr>
<td>Velda Fresquez-Gray, CPC</td>
<td>Wichita</td>
<td>1-800-432-0216 ext. 1674</td>
<td></td>
<td>(316) 269-1674</td>
</tr>
<tr>
<td>Provider Network Services</td>
<td>Topeka</td>
<td>1-800-432-3587(Options)</td>
<td></td>
<td>(785) 291-4135</td>
</tr>
</tbody>
</table>

*Specialty Rep advises the following: AMB, AUD, HAD, RPT, OT, SP, HME/DME, RN, CPTA, COTA

Provider Network Services 1-800-432-3587 Local 785-291-4135

Nicole Ramer, CPC (Provider Network Services)  (785) 291-8330
What Can bcbsks.com Do for You?

Did you know that Blue Cross and Blue Shield of Kansas offers a website, comprising both secure and non-secure sections, where you and your staff can find a wealth of information?

At Your Fingertips

Secure
Availity.com
- Claim Status
- Eligibility

Payer Resources — BCBSKS
- Remittance Advice
- Pre-certification
- Patient ID Search

Provider Section (non-secure) for helpful resources that allow you to:
- Take advantage of online training courses that use multimedia technologies.
- Sign up to receive important email messages when new or updated items have been posted.
- View provider publications, including manuals, policy memos, medical policies and newsletters.
- Register for insurance billing workshops offered regularly throughout the state as well as coding and special workshops scheduled periodically.
- Search provider directories.
- Access State of Kansas and special group information.

Our website is available around the clock.
Go to bcbsks.com today to learn more!
Section 9: Appendices
Specialty-Specific Guidelines

These specialty-specific appendices address items specific to the listed specialties. Each appendix is **NOT** complete as a stand-alone document. It is to be used in conjunction with the entire Business Procedure Manual.

The revision date appears in the footer of each document. Links within the document are updated as changes occur throughout the year.
## REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>01/01/2011</td>
<td>Added &quot;Revisions,&quot; &quot;Preventive Services Quick Reference Guide,&quot; and &quot;Archived Lists&quot; to the Table of Contents</td>
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<td></td>
<td>Changed revision date to &quot;January 2011&quot; from &quot;January 2010.&quot;</td>
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<td></td>
<td>Updated links to current year documents</td>
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<tr>
<td>Page 24 –</td>
<td>Under Box 17, removed &quot;if applicable,&quot; and on last line, &quot;For BCBSKS, Other Source does not apply.&quot;</td>
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<tr>
<td></td>
<td>Added section from Policy Memo No. 1, as follows:</td>
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<tr>
<td></td>
<td>As stated in Policy Memo No. 1, Section XV., Claims Filing:</td>
</tr>
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<td></td>
<td>All contracting providers (except as provided in Section XXV.), who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim.</td>
</tr>
<tr>
<td>Page 25 –</td>
<td>Added wording, &quot;ordering, or supervising provider&quot; under the picture of Box 17 at the top of the page.</td>
</tr>
<tr>
<td></td>
<td>Added &quot;(Not Required)&quot; by Box 17a bullet.</td>
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<td>Deleted Box 17a and associated text..</td>
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<td><strong>Box 17a – Other ID#</strong></td>
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<td>The non-NPI I.D. number of the referring, ordering, or supervising provider refers to the payer assigned unique identifier of the professional.</td>
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<td>The Other I.D. number of the referring, ordering, or supervising provider is reported in 17a.</td>
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<td>Added &quot;identified in Box 17&quot; to explanation under Box 17b.</td>
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<td>Page 37 –</td>
<td>Added a link for the health care reform Preventive Services Quick Reference Guide.</td>
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<td>Added a link for the Archived Lists.</td>
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<td>Page 46 –</td>
<td>Removed PCS certifications from Robyne Goates, Diana Evans, Cheri Iarossi, Debra Meisenheimer, Gwen Nelson, and Velda Fresquez-Gray.</td>
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# REVISIONS

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<td>- Added bullet, ICD-10 Mapping Tool, to the left column</td>
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<td>- Made verbiage in right-hand column parallel (all bullets now begin with a verb—no content change)</td>
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<td>Changed revision date to December, 2011</td>
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<td>- Created live link for Home Medical Equipment Appendix D</td>
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<td>04/20/2012</td>
<td>Changed revision date to April, 2012</td>
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<td>Updated links within the manual to connect to correct documents</td>
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<td>Changed revision date to July, 2012</td>
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<td>Page 46 –</td>
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<td></td>
<td>- Under “Questions We Answer For Providers”, item #7, changed the word “Mail” to “Send”.</td>
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<td></td>
<td>- Item #9, added the verbiage “for TRICARE (TriWest region only)”.</td>
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<td>- Deleted item #10 as it no longer applies.</td>
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<td></td>
<td>10. Initiate Intercept procedures on behalf of providers.</td>
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<tr>
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<td>- Changed all references of “Hotline” to “Provider Network Services”.</td>
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<tr>
<td></td>
<td>- Changed “ARNP” to “APRN”.</td>
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<tr>
<td></td>
<td>- Added LCP and LCMFT to list of providers advised by medical reps.</td>
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<tr>
<td></td>
<td>- Added CPTA and COTA to list of providers advised by specialty rep.</td>
</tr>
<tr>
<td></td>
<td>- Added CPC designation to Nicole Ramer’s name.</td>
</tr>
<tr>
<td>02/06/2013</td>
<td>Changed revision date to February, 2013</td>
</tr>
<tr>
<td></td>
<td>Updated links within the document</td>
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<tr>
<td></td>
<td>Pages 4-16 – Updated all bullets under each policy memo to reflect actual section titles within each policy memo.</td>
</tr>
<tr>
<td></td>
<td>Page 17 – Added verbiage regarding electronic claim submission.</td>
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<tr>
<td></td>
<td>Pages 19-23 – Added the word “member” in parentheses after all references to “insured”, i.e., “… insured (member) …”, within the claim form box instructions.</td>
</tr>
<tr>
<td></td>
<td>Page 23 – Changed box 11a to “if applicable” instead of “not required”.</td>
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<tr>
<td></td>
<td>Also added explanation verbiage under the box to clarify when box 11a is applicable and, therefore, required.</td>
</tr>
<tr>
<td></td>
<td>Page 38 – The Site of Service Listing (with its corresponding link) has been added to the procedure code listings available.</td>
</tr>
<tr>
<td></td>
<td>Page 42 – Under “What is Workers’ Compensation?”, updated the second paragraph.</td>
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<tr>
<td></td>
<td><strong>Old Wording:</strong></td>
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<tr>
<td></td>
<td>On the CMS 1500 claim form, note that it was an on-the-job illness or injury by:</td>
</tr>
<tr>
<td></td>
<td>1. Marking &quot;yes&quot; in Box 10a</td>
</tr>
</tbody>
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# REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Pages/Changes</th>
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| 2/06/2013, continued | 2. Giving the date of the accident or illness in Box 14  
3. Indicating the diagnosis or nature of the illness or injury in Box 21  
**Old Wording:**  
On the CMS 1500 claim form, note that it was an on-the-job illness or injury by:  
1. Marking "yes" in Box 10a  
2. Giving the date of the accident or illness in Box 14  
3. Indicating the diagnosis or nature of the illness or injury in Box 21  
Page 44 – Under “How Do I Reconcile My Accounts?”, verbiage was added to clarify situations when both plans are Blue Plans, or when one of the plans is a commercial carrier other than a Blue Plan.  
Page 46 – Added the instruction “(Select "Code Lists")” under the link to Washington Publishing Company. The code lists may be viewed on-line free of charge.  
Page 49 – Updated the page with Availity® information. |
| 7/18/2013 | Changed revision date to July 2013.  
Page 47 – Replaced Cheri Iarossi, rep, with Christie Blenden, rep.  
Page 48 – Replaced old map with Cheri Irossi to new map with Christie Blenden. |
04/21/2015 | Page 30 – Updated the information on "What Can bcbksks.com Do for You?" page.  
01/01/2016 | Pages 2, 18 – Removed links to Additive and Blank Classification Listings, and Site of Service.  
Page 4 – Updated "Documentation" to "Medical Records".  
Page 5 – Added "Reimbursement for Site of Service", "Collection of Payment", and "Contract Amendment". |